ASSESSMENT PLAN FOR AFC RESIDENTS

Michigan Department of Human Services
Office of Children and Adult Licensing

INSTRUCTIONS:

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Human Services and contains the information required by administrative rule and Section 3 (9) of Act 218, P.A. 1979, as amended.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process.
4. Use additional sheets if necessary and **PRINT CLEARLY.**

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex
			☐ M ☐ F

I. SOCIAL/BEHAVIORAL ASSESSMENT PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community	☐	☐	
B. Communicates Needs	☐	☐	
C. Understands Verbal Communication	☐	☐	
D. Alert to Surroundings	☐	☐	
E. Reads and Writes	☐	☐	
F. Tells Time	☐	☐	
G. Manages Money	☐	☐	
H. Follows Instructions	☐	☐	
I. Controls Aggressive Behavior	☐	☐	
J. Controls Sexual Behavior	☐	☐	
K. Gets Along With Others	☐	☐	
L. Exhibits Self Injurious Behavior	☐	☐	
M. Participants in Social Activities	☐	☐	
N. Smokes	☐	☐	
O. Appropriately Uses Alcohol/Drugs	☐	☐	

See Page 4 for Non-discrimination and ADA statement

Continued on Next Page

II. SELF CARE SKILL ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		
	Yes	No	IF YES, Describe Needs and How The Will Be Met
A. Eating/Feeding	☐	☐	
B. Toileting	☐	☐	
C. Bathing	☐	☐	
D. Grooming (hair care, teeth, nails, etc.)	☐	☐	
E. Dressing	☐	☐	
F. Personal Hygiene	☐	☐	
G. Walking/Mobility	☐	☐	
H. Stair climbing	☐	☐	
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)	☐	☐	
J. Use of Assistive Devices (explain)	☐	☐	
K. Other (explain)	☐	☐	

III. HEALTH CARE ASSESSMENT **PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES, Describe Needs and How They Will Be Met
A. Taking medication	☐	☐	
B. Special Diets	☐	☐	
C. Physical Limitations	☐	☐	
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)	☐	☐	
E. Other Difficulties (Vision, Weight, Allergies, etc.)	☐	☐	
F. Susceptible to Hypothermia or Hyperthermia	☐	☐	

Continued on Next Page

IV. SOCIAL AND PROGRAM ACTIVITIES PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)

	Yes	No	Explain How These Activities Will Be Provided or Encouraged
A. Participates in Religious Practice	☐	☐	
B. Participates in Household Chores	☐	☐	
C. Adult Activity Program	☐	☐	
D. Senior Center	☐	☐	
E. Workshop or job	☐	☐	
F. School	☐	☐	
G. Hobbies/Special Interest	☐	☐	
H. Recreation	☐	☐	
I. Physical Exercise	☐	☐	
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)	☐	☐	
K. Other (explain)	☐	☐	

V. MEDICAL INFORMATION

Name of Primary Physician/Clinic		Telephone Number ( )	
Primary Physician's Complete Address (Street Number and Name)	City	State	Zip Code

V. MEDICATIONS TAKEN AT TIME OF ASSESSMENT

Name of Medication	Who Prescribed	Dosage

Continued on Next Page

MEDICAL OR DENTAL FOLLOW-UPS NEEDED (i.e., check-ups, regular appointments, etc.)

VI. RELEASE OF INFORMATION – RESIDENT OR LEGAL GUARDIAN SIGNATURE ONLY

"By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency and the Michigan Department of Human Services, Office of Children and Adult Licensing, for the purpose of providing appropriate care to me and determining compliance with licensing rules."	
Signature of Resident or Legal Guardian	Date

VII. OTHER INFORMATION

Comments/Special Instructions

VIII. ASSESSMENT PLAN COMPLETION

Date Assessment Plan Was Completed	Name(s) and Position(s) of Person(s) Who Completed Assessment

IX. PLACEMENT OBJECTIVE

A. ☐ Delay/prevent deterioration and movement to a more restrictive setting.
B. ☐ Encourage movement to a less restrictive setting.

X. SIGNATURES

Signature of Resident or Designated Representative Date	Signature of Licensee Date
Signature of Responsible Agency (if applicable) Date	

AUTHORITY: Act 218 P.A. 1979, as amended COMPLETION: Voluntary PENALTY: Violation of Administrative Rule and Act 218 P.A. 1979, as amended	The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.

Michigan Department of Human Services
Office of Children and Adult Licensing
Division Of Adult Foster Care Licensing

AFC – RESIDENT CARE AGREEMENT

This home is licensed by the Department of Human Services to provide foster care to adults.

Name of Licensee	License Number	Type of AFC Home: (Check One)
		☐ AFC Family Home 1 - 6
Name of Home	Address of Home	☐ AFC Small Group Home 1 - 6
		☐ AFC Small Group Home 7-12
		☐ AFC Large Group Home 13 - 20

INSTRUCTIONS:

- This form is to be completed at the time of a resident's admission.
- This form is to be completed by the licensee in cooperation with the resident or his/her designated representative and the responsible agency, if applicable.
- The care and services agreed upon are to be based upon the licensee's written assessment of the amount of personal care, supervision, and protection required by the resident.
- A copy of the signed Resident Care Agreement is to be provided to the resident or his/her designated representative, and the responsible agency, if applicable. A copy is to be maintained by the licensee in the resident's record.
- The Resident Care Agreement is to be reviewed at least annually or more often if necessary.

A. RESIDENT'S OR DESIGNATED REPRESENTATIVE SECTION:

Name of resident

I have designated _____ (name of designated representative) to act as my representative (if applicable).

_____ Resident Signature

_____ Date

1. I have received a copy of the house rules (if applicable). I have had the house rules explained to me, and agree to follow them.
2. I have received a copy of the Adult Foster Care Resident Rights and have had my rights explained to me. I understand that I have a right to voice grievances and present recommendations pertaining to the policies, services, and house rules of the home without fear of retaliation.
3. I agree to provide all personal and identifying information required by the rules.
4. I agree to provide or assist in providing a health care appraisal completed either within the 90 days prior to my admission or within 30 days after an emergency admission. (OCAL-3947 or an approved substitute is to be used)
5. I agree to participate in the completion of a written assessment plan to determine my needs for foster care.
   Yes ☐ No ☐
6. a. I agree to receive assistance in bathing, dressing, or personal hygiene by a staff member of the opposite sex, if a member of the same sex is not available.
   Yes ☐ No ☐

   b. I do not normally require assistance in bathing, dressing, or personal hygiene, but agree to receive assistance by a staff member of the opposite sex should such assistance become necessary.
   Yes ☐ No ☐

7. I agree to entrust the following to the licensee for safekeeping. (See page 3 for information regarding "funds" and "valuables")

a. Funds: ☐ Yes ☐ No	b. Valuables: ☐ Yes ☐ No

8. I agree to have the licensee manage and account for financial transactions on my behalf. ☐ Yes ☐ No
   Expenditures of personal funds over the amount of $_____ require my prior written approval.
9. I understand that this agreement constitutes the fee policy statement required by Family Home Rule 400.1407(11).
   ☐ Yes ☐ No

10. Fees and Payment (Complete appropriate option):

a) I agree to pay the basic fee of $ _____(amount) to _____ (name) on a _____ (daily, weekly, monthly) basis for the services specified in my written assessment and this agreement.

b) For homes receiving contractual payments for cost of care and services, contractual payments will be paid by _____ (name of contractual services provider) per the contract with that agency.

11.(a) Additional Services to be Purchased	11.(b) Fee for Services

12. I have received a copy of the home's Refund Policy. I agree to accept the terms of the Refund Policy should discharge be necessary. (AFC GROUP HOMES ONLY)
☐ Yes ☐ No

13. I have received a copy of the home's Admission and Discharge Policy. I agree to follow the home's discharge procedures. (AFC GROUP HOMES ONLY)
☐ Yes ☐ No

B. LICENSEE SECTION:

Name of licensee

1. I have provided _____ (name of resident or designated representative) with a copy of:

a. The Adult Foster Care Resident Rights ☐ Yes (All Homes)

b. The House Rules/Guidelines (if established) ☐ Yes (All Homes)

c. The Admission and Discharge Policy ☐ Yes (AFC Group Homes Only)

d. The home's Refund Policy ☐ Yes (AFC Group Homes Only)

2. I agree to provide personal care, supervision and protection in addition to room and board for 24 hours a day for this resident.

3. I agree to assure the availability of transportation services.

a. I agree to provide the following transportation services for the basic fee charged: _____

_____

b. I agree to provide the following transportation services at an extra cost of $_____ (List transportation services)

_____

c. Transportation will be provided by other means (describe): _____

4. I agree to provide the additional services as stipulated in Section A.

5. I agree to provide this resident or designated representative with a 30-day written notice before discharging him or her from the home unless emergency discharge is necessary.

6. I have explained to this resident or designated representative that emergency discharge may occur when it has been determined that any one of the following exists:

   a. Substantial risk to the resident due to the inability of the home to meet the resident's needs or assure the safety and well being of other residents of the home. (AFC Group Homes Only)

   b. Substantial risk or an occurrence of self-destructive behavior.

   c. Substantial risk or an occurrence of serious physical assault.

   d. Substantial risk or an occurrence of destruction of property.

7. I agree to notify the resident, the resident's designated representative, and the responsible agency within 24 hours before emergency discharge.

8. Group homes must meet additional discharge requirements. Emergency discharge is to be in accordance with the home's discharge policy. (Please refer to the Home's Discharge Policy for details.)

9. I agree to discuss the possibility of relocation from this home to another with this resident or designated representative. I will obtain written approval from this resident or designated representative, and the responsible agency, if applicable, when relocation has been agreed upon.

10. I agree to provide the following as specified in the resident's written assessment plan:

    a. Direction and opportunity for the growth and development of the resident which are achieved through activities which foster independent functioning, such as dressing, grooming, manners, shopping, cooking, money management, and use of public transportation.

    b. Opportunity for involvement in educational, employment, and day program opportunities.

11. I agree to provide all of the following:

    a. Opportunity for the resident to develop positive social skills.

    b. Opportunity for the resident to have contact with relatives and friends.

    c. Opportunity for community-based recreational activities.

    d. Opportunity for privacy and leisure time.

    e. Opportunity for religious education and attendance at religious services of the resident's religious choice.

12. I agree to handle resident funds as specified in the Resident Funds Part I form (OCAL-2318).

13. (a) The residents incidental needs are as follows: _____
    (please attach additional pages as necessary)

    (b) These incidental needs will be met as follows: _____
    (please attach additional pages as necessary)

14. I agree to accept the following for safekeeping*:
    a. Funds: ☐ Yes ☐ No b. Valuables: ☐ Yes ☐ No

15. I agree to accept responsibility for the management and accounting of this resident's financial transactions. I recognize that I am prohibited from having any ownership interest in the resident's account. Neither I or my family members will accept, take, or borrow money or valuables from a resident nor will I allow this of my employees, their family members, or volunteers who are under my direction.
    ☐ Yes ☐ No

16. I agree to maintain a trust fund account for this resident which will be kept separate and apart from all other accounts. I recognize that the amount of this trust fund account is not to exceed $1,500.00. (The $1,500.00 limit applies to AFC Family Homes Only.)
    ☐ Yes ☐ No

17. I agree to supervise this resident's taking of his or her prescription medication unless otherwise indicated by a written statement from the resident's physician.

C. ADDITIONAL CONDITIONS: (Optional)

Resident:

_____

_____

_____

_____

Licensee:

_____

_____

_____

_____

D. SIGNATURES:

Resident:	Date
Resident's Designated Representative (If applicable)	Date
Licensee or Designee	Date
Responsible Agency (If applicable)	Date

E. ANNUAL REVIEW SIGNATURES: (ONLY IF THERE HAS BEEN NO CHANGE IN <u>THIS</u> AGREEMENT)

Resident:	Date
Resident's Designated Representative (If applicable)	Date
Licensee or Designee	Date
Responsible Agency (If applicable)	Date

*Funds on the premises of a group home cannot exceed $200.00.
*Funds and valuables on the premises of a family home cannot exceed $200.00.
*A trust fund account cannot exceed $1,500.00. (Family Homes Only)

AUTHORITY: Act 218 of PA of 1979, as amended. COMPLETION: Mandatory PENALTY: Violation of Adult Foster Care Administrative Rule	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an DHS office in your area.

RESIDENT FUNDS RECORD
PART I

Michigan Department of Human Services
Office of Children and Adult Licensing

Resident Name	
Facility Name	License Number

INSTRUCTIONS:

1. The licensee is to complete Sections A, B, and C for all residents.
2. A Resident Funds Part II (OCAL-2319) or approved substitute, must be completed for:
   a. All resident payments for adult foster care services as required by R400.14102(1)(v)(I), R 400.15102(1)(0)(I)
   b. Account(s) managed by the licensee for a resident including:

Personal allowance	Work/workshop checks
Other checks or cash such as gifts	Cash
Interest	Dividends
Stocks, bonds or money market funds	Savings, checking accounts
All other applicable funds	

3. The licensee is to keep Resident Funds forms in the resident's record
4. The licensee is to give a copy of the Resident Funds forms to the person(s) responsible for managing the resident's funds.
5. The licensee shall not commingle resident funds with licensee's funds.

SECTION A: The person or persons responsible for the resident's funds is (are):

☐ Resident

☐ Legal Guardian…….

Name Phone Number

☐ Representative Payee…….

Name Phone Number

☐ Adult Foster Care Licensee or Designee……

Name Phone Number

☐ Other……..……..….

Name Phone Number

SECTION B: Please indicate below all applicable accounts managed by the licensee or their designee. All transactions regarding these accounts must be recorded on the OCAL-2319. Name the individual managing account: _____

☐ Payment for AFC

☐ Cash

☐ Checking Account – Joint Checking…….

Name of Bank Account Number

☐ Saving Account – Joint Savings……....

Name of Bank Account Number

☐ Other Account..……....

Name of Bank Account Number

Signature of Joint Account Holder	Signature of Joint Account Holder
(1)	(2)

SECTION C: **I certify that I have no ownership interest in the resident's account.**

Licensee/Designee Signature	Date

THANK YOU FOR YOUR COOPERATION

AUTHORITY: Public Act 218 of 1979 COMPLETION: Mandatory CONSEQUENCE: Adult Foster Care Rule Violation	Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

RESIDENT FUNDS
PART II

Michigan Department of Human Services
Bureau of Children and Adult Licensing

Resident Name	
Facility Name	License Number
Time Period Covered thur	

This form or an approved substitute is to be used to record all resident care payments for adult foster care services.

INSTRUCTIONS:
Please use a separate BCAL-2319 - Resident Funds - Part III for each savings, checking, or other account. One form may be used to account for cash and for payment of adult foster care services. Please attach additional pages as necessary.

Type of Account

☐ SAVINGS ☐ CHECKING ☐ CASH ☐ PAYMENT FOR ADULT FOSTER CARE SERVICES ☐ OTHER (Specify) ▶

Date	Reason for Transaction	Resident or Designated Representative Signature	License or Designee Signature	Deposit Amount (+)	Withdrawal Amount (-)	Balance Forwarded $

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AUTHORITY: 1979 PA 218 R 400.14315(3) and R 400.153.15(3)
COMPLETION: Mandatory
CONSEQUENCE: Adult Foster Care Rule Violation

DISTRIBUTION: PART 1 - Resident Record
PART 2 - Resident or Designated Representative

HEALTH CARE APPRAISAL

Michigan Department of Human Services • Office of Children and Adult Licensing

Licensee Name	Resident Name		Case Number
AFC Facility Name	Facility License Number	Worker Name / Load Number	Worker Phone Number

Release of General Medical Information: By signing this form, I understand that I am authorizing the release of medical information concerning me to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Human Services, Office of Children and Adult Licensing for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident / Legal Guardian	Title	Date

Release of HIV/AIDS Information: By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency, and the Michigan Department of Human Services, Office of Children and Adult Licensing, for the purpose of providing appropriate care to me and determining compliance with licensing rules.

Signature of Resident / Legal Guardian	Title	Date

1. Height	2. Weight	3. Ideal Weight Range	4. Blood Pressure	5. Age	6. Sex ☐ MALE ☐ FEMALE

7. Diagnoses

8. Current Medications and Instructions

9. Allergies

10. General Appearance

11. Mental / Physical Status and Limitations

12. Mobility / Ambulatory Status:

☐ Fully Ambulatory ☐ Uses Walker

☐ Uses Cane ☐ Uses Wheelchair

13. Susceptibility to Hyper / Hypothermia and Related Limitations

14. Special Dietary Instructions and Recommended Caloric Intake

15. Physical Exam:

TYPE	NORM	ABN	** DEFERRED
1. Skin			
2. Ears			
3. Nose			
4. Throat			
5. Mouth			
6. Neck			
7. Breasts			
8. Chest			
9. Lungs			
10. Heart			
11. Abdomen			
12. Extremities Upper			
Lower			
13. Feet / Toes			
14. Lymph Nodes			
15. Genitalia			
16. Testes			
17. Spine			
18. Reflexes			
19. Neurological			
20. Rectal			
21. Sexually Transmitted Diseases	☐ YES		☐ NO
22. Other:			

**Deferred, as used here, means examination considered but postponed

Explanation of Abnormalities/Treatment Ordered

16. Other Health-Related Information or Concerns

M.D./D.O./P.A. or R.N. (Please Print Name)

Signature	City	State	Zip Code
Address Title	Date of Signature	Date of Exam	

AUTHORITY: Public Act 218 of 1979 R 400.14301(10) and R 400.15301(10)
COMPLETION: Required. R 400.14310 and R 400.15310
CONSEQUENCE: Violation of AFC Licensing Rules. R 400.14313(3) and R 400.15313(3)

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AFC LICENSING DIVISION - INCIDENT / ACCIDENT REPORT

Michigan Department of Human Services

Name of Facility/Home	License Number	Name of Person Directly Involved ☐ Resident ☐ Employee ☐ Visitor
Facility Address		Address
Facility Phone		City/State/Zip Code
Licensee Name		Phone / Case Number (if applicable)

OTHER PERSON(S) INVOLVED / WITNESSES:

Name ☐ Resident ☐ Employee ☐ Visitor	Name ☐ Resident ☐ Employee ☐ Visitor
Name ☐ Resident ☐ Employee ☐ Visitor	Name ☐ Resident ☐ Employee ☐ Visitor

FACTS OF THE INCIDENT (*ATTACH ADDITIONAL PAGES AS NEEDED*):

Date of Incident	Time ☐AM : ☐PM	Name of Employee Assigned to Resident (If Applicable)	Location of Incident (Kitchen, Yard, etc.):

Explain What Happened / Describe Injury (if any):

Action taken by Staff / Treatment Given:

Corrective Measures Taken to Remedy and/or Prevent Recurrence:

Name of Treating Physician / Health Care / Medical Facility / Hospital	Phone Number	Date Care Given	Time ☐AM : ☐PM

Physician's Diagnosis of Injury, Illness or Cause of Death, if known

PERSON(S) NOTIFIED:

AFC Licensing	Notification Date / Time Written Notice / Date:	Adult Protective Services (if applicable)	Notification Date / Time
Physician or RN (if applicable)	Notification Date / Time	Office of Recipient Rights (if applicable)	Notification Date / Time
Responsible Agency	Notification Date / Time Written Notice / Date:	Law Enforcement Agency (if applicable)	Notification Date / Time
Designated Representative / Legal Guardian	Notification Date / Time Written Notice / Date:	Other (please specify)	Notification Date / Time

SIGNATURE(S):

Signature of Person Completing Report	Print Name and Title	Date
Signature of Licensee / Licensee Designee / Administrator	Print Name and Title	Date

OCAL-4607 (Rev. 7-06) Previous editions 4-05, 7-04 & 1-04 may be used. **COPY DISTRIBUTION:** Resident Record, Licensing Consultant, Responsible agency (if required by rule) and Designated representative.

LICENSING RULES FOR AFC SMALL AND LARGE GROUP HOMES

R 400.15311 Investigation and reporting of incidents, accidents, illnesses, absences, and death.

Rule 311. (1) A licensee shall make a reasonable attempt to contact the resident's designated representative and responsible agency by telephone and shall follow the attempt with a written report to the resident's designated representative, responsible agency, and the adult foster care licensing division within 48 hours of any of the following:

(a) The death of a resident.
(b) Any accident or illness that requires hospitalization.
(c) Incidents that involve any of the following:
(i) Displays of serious hostility.
(ii) Hospitalization.
(iii) Attempts at self-inflicted harm or harm to others.
(iv) Instances of destruction to property.
(d) Incidents that involve the arrest or conviction of a resident as required pursuant to the provisions of section 1403 of Act No. 322 of the Public Acts of 1988.

(2) An immediate investigation of the cause of an accident or incident that involves a resident, employee, or visitor shall be initiated by a group home licensee or administrator and an appropriate accident record or incident report shall be completed and maintained.

(3) If a resident is absent without notice, the licensee or direct care staff shall do both of the following:
(a) Make a reasonable attempt to contact the resident's designated representative and responsible agency.
(b) Contact the local police authority.

(4) A licensee shall make a reasonable attempt to locate the resident through means other than those specified in subrule (3) of this rule.

(5) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.

(6) An accident record or incident report shall be prepared for each accident or incident that involves a resident, staff member, or visitor. "Incident" means a seizure or a highly unusual behavior episode, including a period of absence without prior notice. An accident record or incident report shall include all of the following information:
(a) The name of the person who was involved in the accident or incident.
(b) The date, hour, place, and cause of the accident or incident.
(c) The effect of the accident or incident on the person who was involved and the care given.
(d) The name of the individuals who were notified and the time of notification.
(e) A statement regarding the extent of the injuries, the treatment ordered, and the disposition of the person who was involved.
(f) The corrective measures that were taken to prevent the accident or incident from happening again.

(7) A copy of the written report that is required pursuant to subrules (1) and (6) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted, in writing, by the department.

LICENSING RULES FOR AFC FAMILY HOMES

R 400.1416 Resident health care.

Rule 16. (1) A licensee, in conjunction with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician with regard to such items as medications, special diets, and other resident health care needs that can be provided in the home.

(2) A licensee shall maintain a health care appraisal on file for not less than 2 years from the resident's admission to the home.

(3) A licensee shall record the weight of a resident upon admission and monthly thereafter. Weight records shall be kept on file for 2 years.

(4) A licensee shall make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency by telephone, followed by a written report to the resident's designated representative and responsible agency with 48 hours of any of the following:
(a) The death of a resident.
(b) Any accident or illness requiring hospitalization.
(c) Incidents involving displays of serious hostility, hospitalization, attempts at self-inflicted harm or harm to others, and instances of destruction to property.

(5) A copy of the written report required in subrule (4) of this rule shall be maintained in the home for a period of not less than 2 years. A department form shall be used unless prior authorization for a substitute form has been granted in writing by the department.

R 400.1417 Absence without notice.

Rule 17. (1) If a resident is absent without notice, the licensee or responsible person shall do both of the following:
(a) Make a reasonable attempt to contact the resident's next of kin, designated representative, and responsible agency.
(b) Contact the local police authority.

(2) A licensee shall make a reasonable attempt to pursue other steps in locating the resident.

(3) A licensee shall submit a written report to the resident's designated representative and responsible agency in all instances where a resident is absent without notice. The report shall be submitted within 24 hours of each occurrence.

LICENSING RULES FOR AFC CONGREGATE FACILITIES

R 400.2404 Illnesses and accidents.

Rule 404. (1) In case of an accident or sudden adverse change in a resident's physical condition or adjustment, a congregate facility shall obtain needed care immediately and notify the responsible relative and the person or agency responsible for placing and maintaining the resident in the congregate facility.

(2) An occurrence of a reportable communicable disease as defined by the laws of this state or the rules implementing such laws shall be reported immediately to the local health department and the department.

(3) Immediate investigation of the cause of an accident or incident involving a resident, employee or visitor shall be initiated by a congregate facility licensee or administrator and an appropriate accident record or incident report completed and maintained. Within 72 hours, serious accidents requiring medical attention shall be reported to the department for remedial review.

R 400.2405. Deaths of Residents.

Rule 405. When a resident dies, a congregate facility licensee or administrator shall notify immediately the resident's physician, the next of kin or legal guardian and the person or agency responsible for placing and maintaining the resident in the congregate facility. Statutes applicable to the reporting of sudden or unexpected death shall be observed. The death shall be reported to the department within 72 hours.

AUTHORITY: P.A. 218 of 1979. COMPLETION: Is Required CONSEQUENCE: Violation of Adult Foster Care Administrative Rule	The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.

AFC-RESIDENT INFORMATION AND IDENTIFICATION RECORD

Michigan Department of Human Services

DIVISION OF ADULT FOSTER CARE LICENSING

Instructions:

1. **Please complete all applicable information on form at the time of the resident's admission.**
2. **Please complete the resident valuables inventory as required on the reverse side of the form**

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License Number

Name		Social Security	Case Number
Veteran Status and Number (If applicable)			Marital Status
Date of Birth	Sex	Home Address (Street, City, Zip Code)	
Next of Kin/Guardian/Designated Representative (Circle appropriate Title)			Telephone Number
Address (Street, City, Zip Code)			
Placing Agency/Person (Name)			Telephone Number
Address (Street, City, Zip Code)			
Date of Admission		Date of Discharge	
Name of Physician			Telephone Number
Address (Street, City, Zip Code)			
Name of Preferred Hospital			
Address (Street, City, Zip Code)			
Religious Preference			

Insurance Information

_____

_____

_____

_____

Burial Provisions

_____

_____

_____

_____

_____

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

Authorized by PA 218, 1979, as amended. Completion is voluntary. However, it is required that resident identifying information be maintained either on this or an equivalent form.

INVENTORY OF VALUABLES

ITEM	DATE RECEIVED	DATE RETURNED

RESIDENT WEIGHT RECORD
MichiganDepartment of Human Services
Adult foster Care Licensing

License Number

INSTRUCTIONS:

1. The resident's weight is to be recorded at the time of admission and once per month thereafter.
2. Unusual or significant weight gain or loss may be explained in the comments section.

Resident Name (Last, First, middle)		
Facility Name and Address		
Weight at Admission	Height (Optional)	Physician's Name

Date Month/Day/Yr.	Weight	Comments	Date Month/Day/Yr.	Weight	Comments

AUTHORITY: P.A. 218 of 1979 as amended
COMPLETION: Voluntary , however Rule 310(3) requires that a resident's weight be recorded at admission and monthly thereafter.

A.F.C. RESIDENT MEDICATION RECORD
Office of Children & Adult Licensing

MICHIGAN DEPARTMENT OF HUMAN SERVICES

MEDICATION NAME AND INSTRUCTIONS FOR USE	TIME OF DAY	**Resident Name:** _____ **Month:** _____ **Year:** _____ **DAY OF THE MONTH** 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Medication Name (Single Dose Only)	**Time of Day**	**DAY OF THE MONTH** 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

SIGNATURE AND INITIALS OF EACH PERSON SIGNING INITIALS ABOVE

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AUTHORITY: P.A.. 218 OF 1979
COMPLETION: Mandatory: Family Home and Group Home Rule Requirements
PENALTY: Violation of Rule R 400.1418 (4) (a) Family Rules, R400. 14312(4) or R400.15312 (4) Group Home Rules